CHANGES RESULTING FROM THE CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT, 2020 RELAVANT TO HOSPITALS AND HEALTH SYSTEMS

MARCH 16, 2020

THE CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT, 2020

Passed on March 4, 2020, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (the "Act"), allocates, among other multi-year funding, $8.3 billion for federal, international, and local preparedness and response activities related to challenges posed by COVID-19. The release of these funds will likely result in ongoing updates on coverage and practice adjustments meant to address COVID-19 challenges. For example, the Centers for Disease Control and Prevention (the "CDC") has entered a "cost-sharing agreement" with Medicare to waive fees for beneficiaries on COVID-19 lab tests and medically necessary hospitalizations. Although there is currently no vaccine for COVID-19, once developed, it will be fully covered under Part D. Additionally, with its $6.5 allocation, the United States Department of Health & Human Services (the "HHS") has indicated that it plans to implement a variety of response efforts including procurement of medical supplies for the National Strategic Stockpile. HHS has indicated that more than $3 billion will be used for diagnostics, vaccine and treatment research and development. Provisions of the Act will likely be followed by a second stimulus package which is expected to be finalized when Congress resumes the week of March 23. A brief summary of key current developments relevant to hospitals and health systems is provided below.

HEALTHCARE FACILITIES

The Act permits the CDC to use some of its $2.2 billion allocation to construct, alter, or renovate non-federally owned facilities to prepare and respond at the state and local level and to reimburse state or local costs retrospectively for certain COVID-related activities between January 20 and the date on which CDC enacts the funding. While several states have already been delegated such funding, it does not appear that Virginia has yet received any allocation.

TELEHEALTH

Although the Act grants authority to the Secretary of HHS to temporarily waive certain originating site and geographic requirements for telehealth services provided to Medicare beneficiaries located in an identified "emergency area" during an "emergency period" when provided by a qualified provider, those waivers are not yet in effect. When/if a waiver is granted, to qualify, the provider must have treated the patient within the previous three years or be in the same practice

(i.e., as determined by tax identification number) of a practitioner who has treated the patient in the past three years. Telecommunications requirements are also expected be lessened by allowing Medicare beneficiaries to receive telehealth services via their smartphones (i.e., telephones that allow for real time, audio-video interaction between the provider and the beneficiary). As a practical matter, health care providers must still comply with state telehealth laws and regulations, including professional licensure, scope of practice, standard of care, patient consent, as well as other payment requirements for non-Medicare beneficiaries. Under the anticipated waiver(s), the patient must initiate the service and give consent to be treated virtually, and the consent must be documented in the medical record before initiation of the service. Because the federal government has declared a nationwide public health emergency as a result of the coronavirus, the waiver will apply across the country until there is no longer a nationwide public health emergency.

The codes to be billed for what Medicare defines as "telehealth services" typically include evaluation and management (E/M) codes (for example, 99213, 99214) along with a telehealth Place of Service (POS) code and potentially a modifier (if required by commercial payer). Providers should keep in mind that there are additional services currently available for payment that are not restricted by originating site and other Medicare telehealth regulation, and these remain unaffected. For example:

- The Medicare "communications-based technology" codes (e.g., G2012) are not deemed by CMS to be Medicare "telehealth services," which means they are not subject to the statutory restrictions regarding originating site and rural geography. These services can be furnished even when patients are in their homes, regardless of a national emergency declaration.
- Time-based, online digital E/M codes (99421, 99422, 99423) are available for established patients and similar codes (G2061, G2062, G2063) are available for online patient-initiated assessments provided by qualified non-physician health care professionals.

Hospitals may not bill under OPPS for services provided to patients at home via telehealth. The new Centers for Medicare & Medicaid Services ("CMS") guidance permits only professionals to bill under the MPFS for professional services provided via telehealth in these situations.

COVID TESTING

CMS has announced that Medicare Part B will cover COVID diagnostic testing for dates of service on or after Feb. 4, 2020. Providers of this testing, however, must wait to submit a claim until after April 1, 2020. Diagnostic tests are not generally available yet for use in physician offices, but those providers may currently be collecting specimens and ordering the tests. Typically, if the patient is in a physician office for an E/M service, the specimen collection is bundled into that service. Most contracts do not include specimen collection and providers will need to verify billing requirements with payors.

CMS has also created two Healthcare Common Procedure Coding System (HCPCS) codes to report COVID testing:

- Labs that test using the CDC 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the new HCPCS code (U0001). This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2.

- The HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On Feb. 29, 2020, the FDA issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 tests. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. Diagnosis coding for coronavirus is also available.

CONCLUSION

Hospitals and health systems should closely monitor state and federal COVID-19 related regulatory changes and be prepared to implement associated practices in order to best serve their patient populations during the state of emergency.

For questions, please contact a member of our COVID-19 Taskforce.